

Dr Wan Tinn Teh
MBBS FRANZCOG MRMed
Gynaecologist & Fertility Specialist
Suite 126, 55 Flemington Rd, North Melbourne 3051
Ph: 1300 926 834
Fax: 1300 834 926

New Patient Registration Form

Personal Details

Title (*Please circle*): Mr Mrs Ms Miss Dr

First name: _____ Surname: _____

DOB: ___ / ___ / _____

Address: _____

Contact (Home): _____ (Mobile): _____ (Work): _____

Email (*optional*): _____

Medicare Card: _____ Ref no: ___ Exp: ___ / ___

Private Health Insurance: _____

Membership no: _____

Next of Kin: _____ Relationship: _____ Mobile: _____

Partner's Details (if applicable)

Title (*Please circle*): Mr Mrs Ms Miss Dr

First name: _____ Surname: _____

DOB: ___ / ___ / _____

Relationship: _____ Contact No: _____

Medicare Card: _____ Ref no: ___ Exp: ___ / ___

GP Details

Name: _____

Address: _____

Phone: _____ Fax: _____

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Fees

Please note that this is a private billing clinic and full payment is required on the day of consultation. If you have any queries about fees, please contact reception prior to your appointment. Additional fees may arise during treatment.

Cancellation

A reminder text will be sent to you prior to your appointment. A cancellation fee may apply if less than 24 hours' notice is given.

Privacy statement

I _____ (print name) understand that this medical practice collects my information for the primary purpose of providing quality healthcare. Information I provide may be used for administrative purposes including billing and compliance with Medicare and Health Insurance Commission Insurance requirements. Information may also be sent to other practitioners involved in my care while at other times, information regarding my care may need to be attained from other healthcare providers. Confidentiality will always be maintained if any information related to my care is used in research, quality assurance or educational purposes.

Signature _____ Date _____